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DOI:

[10.12968/bjha.2018.12.8.398](https://doi.org/10.12968/bjha.2018.12.8.398)

Document Version

Peer reviewed version

[Link to publication record in King's Research Portal](#)

Citation for published version (APA):

Kessler, I., & Nolan, R. (2018). The Construction of Assistant Practitioner Role in a Community Children's Team. *British Journal of Healthcare Assistants*, 12(8), 398-404. <https://doi.org/10.12968/bjha.2018.12.8.398>

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Constructing an Assistant Practitioner Role in a Children's Community Team

*'No two assistant practitioners are the same
because their role is unique to the area they
work in.'*
(Matron, Torbay)

1. Introduction

Initially developed by the Modernisation Agency in 2002 as part of an attempt to introduce new ways of working into a 'patient –centred' NHS, the assistant practitioner (AP) role has generated extensive interest and debate amongst policy makers and practitioners. This reflects the fact that the role was originally conceived in broad terms with considerable scope to deliberate on its nature and consequences. Consolidated at pay band 4 under the NHS Agenda for Change grading structure in 2004, the AP has been defined by Skills for Health (2011:4) as, 'Requiring a level of knowledge and skill beyond that of the traditional healthcare assistant or support worker.... (and) undertaking clinical work in domains that have previously only been within the remit of registered professionals.' Typically based on a level 5 qualification, the AP role has, nonetheless, remained unregistered and underpinned by variety of training models and entry routes.

From an organisational perspective, the presentation of the AP role in such a permissive manner represented a 'double-edged sword'. Framed in non-prescriptive terms, the role became a flexible resource, able to meet local circumstances and needs. Yet this very permissiveness required NHS trusts proactively to introduce a new support role with the potential to disrupt clinical routines and the delicately balanced distribution of tasks across the workforce. These competing perspectives perhaps account for the mixed picture presented on the take-up of the AP role. Survey data highlighting the patchy use of assistant practitioners and the barriers faced in introducing the role (Spilsbury et al, 2007), sit alongside many accounts of how APs have effectively been developed in different settings: for example, general practice (Hicking-Woodison, 2014), cancer research laboratories

(Arrowsmith, 2010), physiotherapy in post-operative cardiothoracic care (Eden, 2012), and accident and emergency departments (Butler, 2007).

This evidence base suggests that the AP role takes many forms, with its introduction subject to a degree of organisational challenge and uncertainty. In this article we examine the development of an AP role in the children's community team at Torbay and South Devon NHS Foundation Trust (henceforth Torbay): a role contributing to service provision for children with life-limiting and -shortening conditions. The role was introduced some eight years ago, and initially undertaken by a single post holder for a period of around three years. Our focus is on why and how this role emerged and on its consequences for different stakeholders. The article is in four parts: research themes; the methods; the findings; and their discussion.

2. Research Themes

Debate in the research literature on the AP role has revolved around various closely related issues:

- **Rationale:** Discussion on the rationale for the introduction of the role has tended to distinguish between drivers associated with service design and quality, and with cost efficiency. The distinction is highlighted by the Royal College of Nursing (2009), which 'recognises the value of this (AP) role for patients and the nursing team (but) would become concerned if (it) were to be introduced merely as a means of reducing costs.' Cost reduction has been associated with substitution, and a resulting dilution in skill mix. Indeed, in the context of austerity, attention has been drawn to the potential use of APs as a response to financial pressures (Mathews, 2015), although a recent survey suggests that this is rarely the primary driver for the role's introduction (Kessler and Nath, 2018).

The value of the AP to different stakeholders has partly rested on the role's capacity to relieve registered professionals of more 'routine' tasks, allowing them to concentrate on activities aligned with their capabilities and knowledge. For patients the AP role provides opportunities for service re-design leading to improved care quality. While for support workers themselves the role constitute a new career

development opportunity, and indeed a potential stepping stone into pre-registration training.

- **Form:** The AP's value to stakeholders, particularly service users, is closely associated with the different forms assumed by the role. Again, a broad distinction can be made between AP roles providing on the one hand, generic support and on the other, support resting on more specialist capabilities. Certainly, the AP role was originally conceived in generic terms with its capacity to work across occupational boundaries, and in so doing provide a more integrated care experience. However, many of the AP roles highlighted in the literature have been specialist in character, allowing the post holder to deepen their skills and become experts whether, for example, as a plasterer technician (Butler 2007), surgical assistant practitioner or colorectal support worker (Kessler et al, 2017).
- **Process:** Most attention amongst researchers has been devoted to the processes underpinning the development of new support and indeed other, healthcare roles. This work has highlighted the fluid and contested nature of job boundaries, and the ways in which healthcare professionals seek to protect themselves against challenges to their occupational territories from such emergent roles (Kitchener and Mertz, 2012). More recently studies have explored how new healthcare roles have become established, the most striking being work undertaken by Reay et al (2006) on the introduction of the nurse practitioner role in a Canada. This study highlights how the nurse practitioner became legitimised at the workplace level, suggesting that acceptance rested on a number of micro-processes: providing opportunities for the new role to contribute; fitting into established systems and routines; and proving the role's value to others.

The research themes outlined above are the basis for the questions explored in relation to the Torbay AP role in the community children's team (henceforth children's AP):

- What was the rationale for introducing this role, and what form did it take?

- How was the role developed?
- What were the consequences of the role for different outcomes and stakeholders?

3. Methods

The exploration of the children's AP at Torbay emerged from an earlier study into the trust's general approach to the development of the AP role. This early work involved around twenty interviews with key stakeholders at different levels of the trust: senior managers (SM), educators, ward managers, nurses and APs. It provided the foundation for the current study, undertaken in July 2017, with its sharper focus on the children's AP role. The current study involved interviews covering six actors with a stake in the role:

- Two parents (P) whose children had been supported by the AP.
- The children's community team manager (TM) at the time to role was introduced
- A paediatric specialist epilepsy nurse (EN) who had working closely with the AP.
- The trust education lead (EL) for non-professional development
- The post holder herself (AP).

The interviews were structured around the three research questions, and lasted between 30 and 60 minutes. All interviews were taped and transcribed.

4. Findings

4.1 Rationale and Form

Assistant practitioners have a long history at Torbay, although the trust's approach to the role has shifted over the years. Initially taken up in 2005/6, there was a degree of opportunism associated with the trust's decision to introduce the role. There was funding available from the then strategic health authority to develop AP training programmes, drawn upon by Torbay working in partnership with another trust in the region:

There were pound signs and, “oh we’ve got some money coming in, let’s take it and see if we can do”, without really understanding what the assistant practitioner role would be. (EL)

Such opportunism, however, gave way to a more considered approach by the trust’s senior management on how the AP role should be viewed and used. The trust sought to develop bespoke AP roles, driven by service needs and sensitive to the circumstances of different clinical areas.

Some trusts see the band 4s as a cheaper alternative to registered nurses and haven’t really thought through what you want these people to do ... Torbay has very much thought about where do you want these people, what do you want them to do, and what sort of education do we want to provide? (SM)

The emergence of the AP role in the children’s team at Torbay followed this line of development, being designed to address a specific set of workplace and service needs. These needs revolved around the capacity of a relatively small team, mainly comprising half a dozen specialist nurses, to deal with a workload growing in scale and complexity:

We got overwhelmed very quickly. To provide any quality of service we were immediately making compromises...We took a step back and thought how can we do this differently to improve the services? (TM)

The children’s AP was a response to these reflections. As the first AP developed by the team, the role assumed a somewhat hybrid form, straddling different clinical needs but allowing the postholder to develop certain specialist capabilities. Thus, the role in part supported the team’s paediatric specialist epilepsy nurse, particularly relieving her of increasing administrative burdens and crucially allowing her to concentrate on the essence of her job, the provision of emergency care:

(The children’s AP) would type up the standard emergency protocols. I'd check them, we'd get them off. She'd do the healthcare plans, which I really didn't need to do. Most of my work is children that are seizing, medication reviews, crisis managing: that is my job. (EN)

The other part of the children's AP role involved helping the team more generally in supporting children with a gastrostomy, a surgical procedure inserting a tube through the abdomen wall and into the stomach for feeding or drainage purposes.

We figured it didn't need a registered nurse. We started to build a training package around that: going out and seeing the families in their homes, helping those children who might need a gastrostomy. So once the decision had been made, they would have the right information and it wouldn't be a scary process. (TM)

4.2 Development

With the broad rationale for the role established, the development of the children's AP comprised a number of key processes:

- ***Clarifying the nature of the role:*** This involved identifying the competencies required and the training package to deliver them. It was a process relying on a close, iterative relationship between key partners- the children's team, the trust's education department and the higher education provider, South Devon College. The underpinning educational qualification, the Foundation Degree, as developed by the College, was pivotal in this respect, providing for the development of core competencies in the first year, but in the second allowing for six more specific competencies reflecting the particular needs of the role and the clinical area.
- ***Finding a suitable individual to fill the role:*** The personal profile of the eventual postholder was distinctive in various ways, and arguably essential to the role's establishment. Thus, the selected postholder had already been in the trust for eight years, working as a healthcare assistant for most of the time in an acute children's ward. This combination of features ensured that moving into the new role, the post holder- was familiar with the trust's routines and culture; had experience of a relevant clinical area: and was already known and respected by many members of the community children's team:

The consultant, and the specialist nurses in the team knew me as a healthcare assistant. (AP)

I trusted (AP's name). OK she's not registered but she's got the nous, and she's got all that experience from the ward, and all that experience from before (EN)

- **Recognition and use:** Steps were taken to ensure that the new AP was recognised and used by key stakeholders: other team members, consultants and parents. In part this involved developing routines and ways of working which allowed for tasks to be safely delegated to the AP. Thus, on the epilepsy side, there was 'a lot of dual visits' between the AP and specialist nurse in helping the AP to develop the capacity to write-up draft healthcare plans. To build her knowledge-base, the AP was also sent on a high level paediatric epilepsy training programme delivered by the British Neurological Association. On the gastrostomy side, the AP herself took steps to inform families of her appointment and role, sending a letter to explain 'who I was and then arranging a visit' (AP).

A more substantive example centred on the referral process, highlighting how routines evolved to integrate and leverage the new AP role on the gastrostomy side:

I began sit in on clinics and the paediatric consultants would refer-in other cases. We got the point where when the child was admitted onto the ward, I would get a call from the consultant and I'd go over while they were there, and then follow them home, so they had full support. (AP)

- **Ongoing Development:** The final process relates to the evolution of the role as the postholder gradually grew into it. It was striking how once in post and more knowledgeable, experienced, confident and aware of possibilities, the AP sought to further shape the role beyond its original conception.

We knew she had to do epilepsy and gastrostomy. There was a job description, but the role flew in terms of how much she could take on, mainly because of her ability. (TM)

The role grew and grew and grew and just evolved, and a lot that is down to the person (EN).

This incremental development of the role is illustrated by the AP's acquisition of a competency to instruct parents to re-insert a nasal gastric tube:

A lot of babies going home from the ward who had tubes down their nose and the babies often pulled them out. Parents were having to ring the ward, come into the ward, and wait for somebody to be free to reinsert the tube. I thought why don't we offer that service? So, I undertook a competency that was set by the ward to re-insert and teach parents how to insert tubes as well and assess their practice.

There were other instances of the role evolving. Thus, it was clear that the AP's role in providing in-school support for children with gastrostomies deepened:

One of the main things was around teaching schools and nurseries how to gastrostomy feed, because a lot the children were going into mainstream school and the teaching assistants were expected to give milk feeds for a gastrostomy- quite a few of those. So, I'd go out teach them how to do it, go back and assess them, make sure they were competent in their practice, write protocols for the staff to follow.

4.3 Consequences

In terms of consequences, the AP role was pitched at the right level to meet the needs of various actors with a stake in Torbay's community children's team. Thus, a registered nurse was never likely to be put in place to provide the administrative support for the epilepsy nurse, while a healthcare assistant would simply have lacked the clinical knowledge for the new role.

In general terms, the positive consequences of the role were captured by comments of the then team manager:

I don't think anyone envisaged it would become the success that it did. It was a risk to go down that pathway. You don't know how it is going to turn out. But as a team we believed in (AP's name) and everybody was incredibly supportive, everybody wanted it to work. It became a fundamental part of the team and it supported families. You take that away and the team is going to suffer. (TM)

A number of these benefits are worth unpacking in more detail:

- **Improved care quality:** A number of examples were provided of small but significant improvements in care quality instigated by the children's AP. In one case, the AP had taken steps to ensure that the emergency department and wards had spare and readily available gastrostomy tubes and buttons (the latter needed to prevent a gastrostomy insertion closing if a tube came out). In another instance, the AP had responded to a national patient safety alert on the possibility of infection, possibly leading to death, associated with the insertion of a gastronomy tube. The AP responded by inserting stickers into ward notes and the communication book, drawing attention to the need for an immediate response if parents rang-in to report sign of such infection.

It was the presence of a dedicated assistant practitioner role which allowed the insight and the attention to detail essential to making these changes. As the AP herself noted:

They (the changes noted above) are very simple things, easily overcome. It is just having somebody in post to have the time to think about them. Before, there really wasn't anybody and matters were dealt with in an ad hoc way.

- **Continuity and consistency:** It was this dedicated focus which also ensured that the AP was accessible to the parents and their children, providing a continuous and consistent service:

(AP's name) provided more continuity and consistency than a registered professional would be able to provide: registered professionals are often overstretched. (P)

If (AP's name) wasn't there you'd had to deal with different people for different things: the HCA for the change of a gastrostomy button, and the trained nurse for the other stuff surrounding it. (P)

- **Expertise and high trust:** The expertise of the children's APs generated a service user trust in the role, and consequent willingness to engage with it:

She (AP's name) was the 'go-to' person rather than anyone else in the community team because her background meant she knew what she was doing. She was more competent than a lot of the nursing staff because she was an expert in her field. (P)

- **Quicker discharge:** On the gastrostomy side, preparing parents by teaching them how to feed the child with the tube, speeded-up hospital discharge:

They (the parents) knew how to feed their little one before they even went into hospital. They would be discharged quicker because they would have to learn all that while they were up there prior to discharge. (P)

- **Reduced anxiety, stress and risk:** The children's AP role developed an important pastoral dimension, with the post able to provide emotional support to parents:

I used (AP's name) regularly for the emotional stuff we were going through.

In difficult times, she was a really good support to me. (P)

Less directly, the range of service improvements outlined above also served to reduce service user stress and anxiety: parent capacity to insert a button and prevent to the tube hole closing (likely to occur within around twenty minutes), prevented rushed and often long, costly trips in hospital. More tangibly taking action to keep the hole open obviated the need for surgery to re-insert the tube with its associated risks:

(To get the hole open again) could result in going back into surgery, and for our children anaesthetics are a massive risk because they have life limiting conditions.

The value of the children's AP role was perhaps most clearly apparent in the aftermath of the postholder's departure. The role as originally constituted did not really survive this departure. Initial difficulties in finding a replacement, resulted in the appointment of B3 healthcare assistant but with 'a noticeable gap between what (AP's name) and this new person were able to do' (TL). The departure of this HCA did lead to the appointment of trainee AP taking-on the gastrostomy side of the role, with the intention to appoint another AP to perform the epilepsy component. However, it is clear that the children's AP role as original conceived, and more important, as developed by the post holder, had not been re-constructed.

5. Conclusions

In examining the emergence of the first AP role in the children's community team at Torbay and South Devon NHS Foundation Trust, a number of key issues have emerged, touching on the research literature but also with broader implications for policy makers and practitioners. The first issue relates to the incremental development of new support roles in healthcare. New support roles cannot simply be 'parachuted' into an organisation by national edict. Indeed an apparent strength of the loosely prescribed AP role is its capacity to develop flexibly in response to particular local circumstances and requirements. At Torbay, this was partly reflected in the trust's approach to the AP role, allowing clinical areas to drive the process and to develop bespoke roles. In its design, the children's AP role was idiosyncratic, cutting-across gastrostomy and epilepsy. Nonetheless, this allowed the post holder to develop specialist capabilities and crucially to meet the clearly identified needs of the team. The organic development of the role was further evident in the way the role continued to evolve once the post holder was in place, and more fully able to identify and navigate ways of taking it forward.

The second issue centres on the positive outcomes associated with the role.

Although we have not sought to systematically measure or cost outcomes, it is evident that various stakeholders benefited from the role in differing ways: parents in terms of reduced stress, anxiety and improved preparation and service quality; team members, and particularly the epilepsy nurse, in relieving pressures and allowing the space for them to concentrate on core tasks; even schools and teaching assistant in the training provided; and the trust itself in terms in speedier discharges

and indeed the avoidance of costs that might otherwise have emerged from escalating care needs.

The final issue concerns the fragility of a new healthcare support role. For all its undoubted benefits, the children's AP role as initially developed, did not survive the departure of the first post holder. The team had certainly come realise the value of an AP role, and continued to include such posts within their staffing establishment. But the distinctive combination of activities underpinning the original role could not be re-created, with implications for the value of future AP roles and how stakeholders engaged with the. We would argue that this fragility lies in the fact that the development of the original role was heavily entwined with capabilities and approach of the individual post holder. This should not detract from the possibility of preserving new healthcare support roles. However, management does need to consider how the capabilities and routines of the post holder in a new role can be captured and preserved, and to formulate a succession plan to ensure the development of individuals with the capacity and competence to move into a new role if, and when, the position becomes vacant.

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